BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GREGORY PITHAN** **6242 Warner Avenue Apt 27G** **Huntington Beach, CA 92647** **Registered Nurse License No. 628126** RESPONDENT	Case No. 2011-791 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about March 18, 2011, Complainant Louise R. Bailey, M.Ed.,RN, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2011-791 against Gregory Pithan (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about October 17, 2003, the Board of Registered Nursing (Board) issued Registered Nurse License No. 628126 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on May 31, 2009 and has not been renewed.

3. On or about March 18, 2011, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2011-791, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record which, pursuant to Business and Professions Code section 136 and/Title 16, California Code of Regulation, section 1409.1, is required to be reported and maintained with the Board, which was and is:

6242 Warner Avenue Apt 27G

Huntington Beach, CA 92647.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. On or about April 13, 2011, the Certified Mail documents were returned, and on April 12, 2011, the First Class Mail documents were returned, both marked by the U.S. Postal Service, "Attempted Unknown"."

6. Business and Professions Code section 2764 states:

The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with an investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license.

7. Government Code section 11506 states, in pertinent part:

(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

8. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived his right to a hearing on the merits of Accusation No. 2011-791.

9. California Government Code section 11520 states, in pertinent part:

(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

10. Pursuant to its authority under Government Code section 11520, the Board after having reviewed the proof of service dated March 18, 2011, signed by Kami Pratab, and the returned envelopes finds that the Respondent is in default. The Board will take action without further hearing and, based on Accusation No. 2011-791 and the documents contained in Default Decision Investigatory Evidence Packet in this matter which includes:

Exhibit 1: Pleadings offered for jurisdictional purposes;

Exhibit 2: License History Certification for Gregory Pithan, Registered Nurse License No. 628126;

Exhibit 3: Affidavit of Annette Rodriguez;

Exhibit 4: Certification of costs by Board for investigation and enforcement in Case No. 2011-791 and

Exhibit 5: Declaration of costs by Office of the Attorney General for prosecution of Case No. 2011-791

The Board finds that the charges and allegations in Accusation No. 2011-791 are separately and severally true and correct by clear and convincing evidence.

11. Taking official notice of Certification of Board Costs and the Declaration of Costs by the Office of the Attorney General contained in the Default Decision Investigatory Evidence Packet, pursuant to the Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement in connection with the Accusation are $6,614.25 as of April 27, 2011.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Gregory Pithan has subjected his following license(s) to discipline:

a. Registered Nurse License No. 628126

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's license(s) based upon the following violations alleged in the Accusation, which are supported by the evidence contained in the Default Decision Investigatory Evidence Packet in this case.

a. Violation of Business and Professions Code section 2761(a)(1) - Unprofessional Conduct, Gross Negligence.

b. Violation of Business and Professions Code section 2762(a) - Obtaining or possessing controlled substances without a prescription.

c. Violation of Business and Professions Code section 2762(b) - Use of controlled substance or alcohol to an extent or in a manner dangerous or injurious to oneself and others.

d. Violation of Business and Professions Code section 2762(e) - Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to a controlled substance.

ORDER

IT IS SO ORDERED that Registered Nurse License No. 628126, heretofore issued to Respondent Gregory Pithan, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on July 28, 2011.

It is so ORDERED June 28, 2011.

Jeannine K. Graves

JEANNINE K. GRAVES
President
Board of Registered Nursing
Department of Consumer Affairs

Attachment:

Exhibit A: Accusation No. 2011-791

Exhibit A

Accusation No. 2011-791

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GREGORY PITHAN** **6242 Warner Avenue, Apt 27G** **Huntington Beach, CA 92647** **Registered Nurse No. 628126** Respondent.	Case No. 2011-791 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about October 17, 2003, the Board of Registered Nursing issued Registered Nurse License Number 628126 to Gregory Pithan (Respondent). The Registered Nurse License expired on May 31, 2009, and has not been renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in relevant part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

7. Section 2761 of the Code states, in relevant part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

8. Section 2762 of the Code states, in relevant part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

10. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

"(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

DRUG STATUTES

11. Dilaudid is a brand name for Hydromorphone. Hydromorphone is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(k), and a dangerous drug as designated by Business and Professions Code section 4022.

12. Valium is a brand name for Diazepam. Diazepam is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(3)(d)(9), and a dangerous drug as designated by Business and Professions Code section 4022.

13. MS Contin is the brand name for Morphine Sulfate. Morphine Sulfate is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M), and a dangerous drug as designated by Business and Professions Code section 4022.

14. Lorazepam is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(3)(d)(16), and a dangerous drug as designated by Business and Professions Code section 4022.

COST RECOVERY

15. Section 125.3 of the Code provides, in relevant part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE
(Unprofessional Conduct-General)
(Bus. & Prof. 2761(a))

16. Respondent has subjected his Registered Nursing License to disciplinary action under Code section 2761, subdivision (a), in that Respondent acted unprofessionally while working as a registered nurse at Kaiser Santa Clara Medical Center Emergency Department (Kaiser-Santa Clara). Between June 9, 2008 and July 16, 2008, Respondent incompetently handled and administered medications. Further, he failed to properly chart the removal and use of controlled substances from the Pyxis machine.[1] The circumstances are as follows:

[1] A Pyxis machine is a computerized management, storage, and medication-dispensing system used in health-care facilities to maintain control of controlled substances. Medical (continued...)

17. During 2008, Respondent was an employee of Staffing U.S.A., a nursing contracting company. In June of 2008, Respondent subcontracted through Nurse Finders, another nursing contracting company, to work 12-hour days at Kaiser-Santa Clara from June 9, 2008 to September 6, 2008. However, on or about July 17, 2008, Kaiser-Santa Clara wrote and sent to Nurse Finders a dismissal letter and a "Do Not Send Notice" regarding Respondent. This was because of Respondent's actions on July 16, 2008, explained below.

18. On July 16, 2008, Respondent was twenty minutes late returning from his break to the emergency room because he fell asleep in the employee lounge. Another nurse noticed respondent sleeping and reported it to Kaiser-Santa Clara officials. Later that day, Respondent was summoned to Kaiser-Santa Clara Emergency Department Management Office for a meeting to review his nursing documentation with a Charge Nurse, the Director of Nursing Practice at Kaiser-Santa Clara, and the Interim Director of Kaiser-Santa Clara Emergency Department. Before the meeting began, Respondent said he needed to go to the bathroom and was escorted out of the office by a security officer. After leaving the office, Respondent told the security officer to cancel his contract and gave him his Kaiser-Santa Clara identification badge. Respondent did not return to work and never contacted Kaiser-Santa Clara Emergency Department.

19. Subsequently, officials at Kaiser-Santa Clara conducted a drug audit of Respondent's removal of controlled substances from the Pyxis machine. They also reviewed 63 related patient records for the period of June 9, 2008 to July 16, 2008. In 50 of the records that they reviewed Kaiser-Santa Clara officials found discrepancies regarding the charting of medications. Included in these discrepancies were instances where Respondent removed controlled substances from the Pyxis machine without a physician's order, failed to document waste or otherwise account for unused controlled substances, and removed controlled substances from the Pyxis machine for unidentified and untraceable patients. Further, the drug audit showed that, in total, Respondent removed 74 mg of injectable Hydromorphone, 36 mg of injectable Morphine Sulfate, 14 mg of injectable Diazepam, and 2 mg of injectable Lorazepam from the Pyxis machine during this

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personnel are provided access to the Pyxis machine by using an assigned password.

period which is not accounted for in hospital records. The failure to properly chart the administration and use of controlled substances removed from the Pyxis machine is inconsistent with the policies and procedures at Kaiser-Santa Clara. This conduct does not meet the standard of care for registered nurses.

SECOND CAUSE FOR DISCIPLINE
(Unprofessional Conduct- Unlawful Possession and Charting of Controlled Substances)
(Bus. & Prof. 2762 (a) & 2762(e))

20. Respondent has subjected his Registered Nurse License to disciplinary action under Code sections 2762, subdivision (a) and 2762, subdivision (e), in that he possessed numerous controlled substances which were not authorized by a physician. In addition, while working as a registered nurse at Kaiser-Santa Clara from June 9, 2008 to July 16, 2008, he made unintelligible and false entries in hospital records regarding the removal and handling of controlled substances from the Pyxis machine. Inconsistent and unintelligible documentation regarding possession of controlled substances from the Pyxis machine were identified in at least 13 patient charts and are explained below.

Patient 1

21. On June 9, 2008, at about 8:17 p.m., Respondent removed one dose of injectable Dilaudid 2 mgs under Patient 1's name from the Pyxis machine without a physician's order. Further, there was no documentation that the medication was administered or wasted.

Patient 2

22. On June 10, 2008, at about 4:18 p.m., Respondent removed one dose of injectable Dilaudid 2 mgs under Patient 2's name from the Pyxis machine without a physician's order. Respondent removed the dose after Patient 2 had been discharged from the Emergency room. There is no documentation that the medication was administered or wasted.

Patient 3

23. On June 13, 2008, Patient 3 had a physician's order for a maximum dosage of 6 mgs of Dilaudid. However, Respondent removed 9 mgs of Dilaudid from the Pyxis machine between 8:02 a.m. on June 13, 2008, and 12:24 a.m. on June 14, 2008, under Patient 3's name. Respondent documented that he administered 3 mgs of Dilaudid to Patient 3 and wasted 3 mgs of

Dilaudid. There is no documentation that the remaining 3 mgs. of Dilaudid was administered or wasted.

Patient 4

24. On June 14, 2008, Patient 4 had a physician's order for Dilaudid 1 mg every four hours as needed for pain. Respondent removed one dose of Dilaudid 2 mgs from the Pyxis machine at 7:48 p.m. Respondent documented that he administered to Patient 4, 1 mg of Dilaudid at 8:00 p.m. However, there is no documentation that the remaining 1 mg of Dilaudid was administered or wasted.

Patient 5

25. On June 19, 2008, Patient 5 had a physician's order for Valium 5 mg. At 1:23 p.m. Respondent removed from the Pyxis machine a Valium 10 mg syringe under Patient 5's name. Respondent documented that he administered 1 mg of Valium to Patient 5. There is no documentation that the remaining 9 mgs of Valium was administered or wasted.

Patient 6

26. On June 24, 2008, Patient 6 had a physician's order for Valium 5 mg. At 6:34 p.m. Respondent removed from the Pyxis machine one Valium 10 mg syringe under Patient 6's name. Respondent documented that he administered 5 mgs of Valium to Patient 6. There is no documentation that the remaining 5 mgs of Valium was administered or wasted.

Patient 7

27. On June 27, 2008, at 7:30 p.m., Respondent removed from the Pyxis machine one injectable syringe of Dilaudid 2 mgs under Patient 7's name. The Pyxis machine report indicates that on June 27, 2008, Respondent wasted 2 mgs of Dilaudid at 7:40 p.m. There was no physician order for Dilaudid for Patient 7. In fact, Patient 7 died on June 27, 2008, at 5:25 p.m.

Patient 8

28. On July 1, 2008, Patient 8 had a physician's order for Dilaudid 1 mg. At 4:10 p.m., Respondent removed one dose of injectable Dilaudid 1 mg from the Pyxis machine under Patient 8's name. There is no documentation that the medication was administered or wasted.

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Patient 9

29. On July 3, 2008, at 10:19 a.m., Respondent removed one dose of injectable Dilaudid 1 mg under Patient 9's name. There is no documentation that Respondent administered or wasted the dose of one injectable Dilaudid 1 mg.

Patient 10

30. On July 7, 2008, at 8:17 p.m., Respondent removed one dose of injectable Dilaudid 1 mg under patient 10's name. There was no physician order for Dilaudid 1 mg injectable. Further, there is no documentation that the medication was administered or wasted.

Patient 11

31. On July 7, 2008, at 4:09 p.m., Respondent removed one dose of injectable Dilaudid 1 mg under Patient 11's name from the Pyxis machine without a physician's order. There is no documentation that the medication was administered or wasted.

Patient 12

32. On July 11, 2008, at 7:21 p.m., Respondent removed one dose of injectable Dilaudid 2 mgs under Patient 12's name from the Pyxis machine without a physician's order. The Pyxis machine indicates that Respondent wasted 1 mg of Dilaudid at 7:31 p.m. However, there is no documentation that the remaining 1 mg of Dilaudid was administered or wasted.

Chart 13

33. On July 14, 2008, at 5:24 p.m., Respondent removed one Morphine Sulfate 4 mg syringe for "Emergency 3." However, there is no corresponding medical record for this removal from the Pyxis machine. Further, there is no documentation that this medication was administered or wasted.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 628126, issued to Gregory Pithan;

2. Ordering Gregory Pithan to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/18/11

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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